EDITORIAL

Future of District Mental Health Programme

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BACKGROUND

India is the first developing country to formulate the National Mental health Programme (NMHP) based on the principle of decentralized and deprofessionalised mental health care[1]. The approach was to integrate mental health with general health services, also referred to as community psychiatry initiative[2]. A model delivery of community based mental health care at the level of district was evolved and field tested in Bellary district of Karnataka by NIMHANS during 1986-1995. The Central Government launched the District Mental Health Program (DMHP) as a 100% centrally sponsored scheme for first five years, at the national level during the 9th Plan as pilot project. It was launched in 1996-1997 in four districts, one each in Andhra Pradesh, Assam, Rajasthan, and Tamil Nadu, with a grant assistance of 22.5 lakhs each. DMHP was implemented in 27 Districts across 22 states/UTs in the 9th Plan. The DMHP was extended to 7 districts in 1997-1998, five districts in 1998 and six districts in 1999-2000. During the Tenth Five Year Plan, the DMHP was extended to 127 districts in the country[3].

During the 10th Five Year Plan, NMHP was restrategized and it became from single pronged to multi-pronged programme for effective reach and impact on mental illnesses. DMHP was redesigned around a nodal institution, usually the zonal medical college. The thrust areas were to expand DMHP to 100 districts all over the country, modernization of mental hospitals in order to modify their present custodial role, upgradation of Psychiatry wings of Govt. Medical Colleges/General Hospitals and enhancing the psychiatry content of the medical curriculum at the undergraduate as well as postgraduate level, strengthening the Central and State Mental Health Authorities with a permanent secretariat, IEC Activities and Research & Training in the field of community mental health, substance abuse and child/ adolescent psychiatric clinics for improving service delivery[4].

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But 10th plan could not meet the objectives of NMHP which necessitated adoption of revised national mental health programme in 11th Plan. During the 11th Five Year Plan, it has been proposed to decentralize the programme and synchronize with National Rural Health Mission for optimizing the results. The main components of NMHP that have been proposed are [5, 6]:

- To establish Centres of Excellence in Mental Health by upgrading and strengthening of identified existing mental hospitals for addressing acute manpower shortage.
- To provide impetus for development of Manpower in Mental Health
- Spill over of 10th Plan schemes for modernization of state run mental hospitals and upgradation of psychiatric wings of medical colleges/general hospitals.
- District Mental Health Programme with added components of Life Skills training and counseling in schools, counseling service in colleges, work place stress management and suicide prevention services.
- Research in mental health
- IEC activities to remove stigma attached to mental illnesses
- NGOs and Public Private Partnership for implementation of the Programme to increase the outreach of community mental health initiatives under DMHP.

- Monitoring at Central/State/District level to facilitate implementation of various components of NMHP and evaluation

DISTRICT MENTAL HEALTH PROGRAMME[3]

The Objectives of DMHP are:

1. To provide sustainable basic mental health services to the community and to integrate these services with other health services;
2. Early detection and treatment of patients within the community itself;
3. To see that patients and their relatives do not have to travel long distances to go to hospitals or nursing homes in the cities;
4. To take pressure off the mental hospitals;
5. To reduce the stigma attached towards mental illness through change of attitude and public education;
6. To treat and rehabilitate mental patients discharged from the mental hospitals within the community

The strategies for achieving these objectives are: i. Training programmes of all workers in the mental health team at the identified Nodal Institute in the State. ii. Public education in the mental health to increase awareness and reduce stigma. iii. OPD and indoor services for early detection and treatment. iv. Providing valuable data and experience at the level of community to the state and Centre for future planning, improvement in service and research.

For DMHP funds are provided by the Govt. of India to the state governments and the nodal institutes to meet the expenditure on staff, equipments, vehicles, medicine, stationary, contingencies, training, etc. for initial 5 years and thereafter they should manage themselves.

Evaluation of DMHP [7]

During 2008-2009 evaluation of DMHP covering 20 of the 127 districts was carried out by Indian Council of Marketing Research (ICMR), New Delhi to assess the functioning of DMHP objectively and critically and to suggest future expansion of the scheme along with improvement in implementation if any, based upon the evaluation. ICMR, a division of Planman Consulting (India) Pvt. Ltd. visited 20 DMHP districts and 5 Non-DMHP districts (as control). The DMHP beneficiary Districts were chosen proportionately from 9th and the 10th Plan period. The following are the main findings of the evaluation:

"One third of the districts under the 9th plan have utilized over 99%, one third has utilized 63-91%, and rests have utilized 37-47% of the total amount they have received. This is mainly due to administrative delay, difficulty in recruiting and retaining qualified mental health professional, low utilization in training and IEC components. In Case of the 10th plan districts, most of the districts had received only the 1st installment under DMHP. Of the grant received one third have utilized more than 90%, half of the districts spent 51-87% and rests of the districts the programme has recently started….. Most of the districts had not utilized the full amount for training due to delay in implementation. …..The expenditure on ... training and IEC components which requires a lot of ground work, coordination and networking in the community is below par in most of the districts. This is mainly due to lack of organizational skills in the DMHP team, low community participation in the programme and lack of coordination with the district health system which comes under a different department. ….. Regarding availability of drugs, only 25% of the districts reported that there has been a regular inflow of drugs. …. This is because of lack of dedicated drug procuring mechanism for DMHP and financial authority to the nodal centre. …. About 61% of the beneficiaries accessed the district hospital as their first point of contact. The percentage of patients accessing CHCs (12.7%) and PHCs (11.5%) were found to be low".

NORTH EASTERN EXPERIENCE

Mere allocation of fund has nothing to do with the successful implementation of any programme. Now we have enough evidence from the ongoing DMHPs. We were part of the recent inspection of the Districts under District Mental Health Programmes (DMHP) by Central Mental Health institutions. What we have seen in the DMHPs in the north eastern states is not at all

encouraging. The scenario is not different from other states also as seen in the evaluation by ICMR.

The training of all categories of personnel is emphasized in DMHP to face the challenge of shortage of professional manpower. But many districts could not train even 50% of the medical officers in the district. The figure is 34.3% in Goalpara, 15.8% in Tinsukia , 26.1% in Nalbari, 39.7% in Marigaon in Assam, 0% in East Siang, 0.70% in Papumpare (Naharlagun) of Arunachal Pradesh. Surprisingly, Papumpare district where DMHP started in 1998-99 trained just a single medical officer under DMHP out of 142 medical officers at a cost of several lakh of rupees. He was sent to NIMHANS for one year period but he is also no more associated with the programme. For paramedical staff the scenario is worse.

The basic tenet of DMHP was decentralization i.e. appropriate mental health service should be made available at the doorstep of the people. It should be accessible at the sub-centre and village level. But in reality it is far from truth even in those districts which have completed 5 year term of central assistance and was taken over by state government. The skeleton service of mental health care is restricted to district hospital only. The non-psychiatrist medical officers are hardly involved in the implementation of the programme. The minimum training of the health workers that is supposed to provide comprehensive health care at the most peripheral level did not materialise in most of the districts. Even the trained mental health professionals are transferred from the DMHP to other posts in state health services. In another case several lakh of rupees were shown to be spent in training but there is no record of the name of paramedical staff/ health worker who were trained under DMHP, duration of training, method of selection, their current place of posting, how they have contributed to DMHP after the training etc.

According to norms DMHP team should be trained at the nearest training institute. But some of the nodal officers are ignorant about the training institutes which are region wise identified for this purpose. There was no communication from the ministry also. The identified centres are NIMHANS, Bangalore for southern states, IHBAS, Delhi for northern states, LGBRIMH, Tezpur for northeastern states, Institute of Mental Health and Neurosciences, Pune for Western states, CIP, Ranchi and RINPAS for eastern states. It seems there is no coordination among the Centre, the State Nodal officers and the identified institutes. Because of which even the paramedical personnel were sent to NIMHANS, Bangalore for training at a huge cost.

The objectives of the programme are not achieved till today after lapse of more than one decade. This indicates that there is a poor commitment of the government, psychiatrists, and community at large. The programme has given more emphasis on the curative services to the mental disorders and preventive measures are largely ignored[8]. It is beyond doubt that more public awareness programmes are required. A huge amount of money was earmarked for IEC activities to increase public awareness about mental illness. Here also the programme failed abysmally in some districts. A classic example is this. In a district where large majority of the people are illiterate, pamphlets in English were printed as part of IEC activities. The argument given was that there are many dialects in that particular state so it is not possible to publish IEC materials in each and every dialect. But the distribution of materials in English to this group of people is unlikely to serve any purpose. Moreover, as part of IEC activities, Mental Health Act, 1987 was also printed. This must have cost several thousands of rupees at the minimum if not in lakh. This is sheer wastage of public money. This is because MHA- 1987 is freely available in the market with nominal price. Moreover this Act is hardly of use for the laymen. So, huge stock of copies of MHA-1987 is lying in the office of the nodal officer. It is not very difficult to guess whose interest is served by such action.

According to the operational guideline[9], states are required to submit proposals under various schemes of the programme. Based upon these proposals from the states funds are released to the State Health Society for implementation as per the scheme guidelines. State nodal officer for NMHP will represent the programme in the State Health Society and get the grant released for various districts and institutions as per the scheme/guidelines. This norm is also not followed by various state Governments. Some state government took several years after the 1st installment from the Central government to appoint the

state nodal officer. Obviously, there is long delay in initiating the programme for which the utilization certificate could not be provided within the stipulated time. As a sequale of this, the programme did not receive the successive installments and the programme had to be withdrawn. There is an example of having practically two State nodal officers, one, a senior official from state health service, for those districts which already completed five years term and are taken over by state government and the other, a psychiatrist for those districts which are getting central grants and yet to complete five years . There is no coordination between the two nodal officers. Neither the DMHP psychiatrists, nor the joint director of Health services of the districts were ever taken into confidence for the financial matter by the concerned official of the directorate of health services of the state. In the district level there was no documents related to financial matter for monitoring. There is an allegation that there is frequent change of officers in the centre who look after this programme, because of which there is delay in issuing subsequent installment even after submitting utilization certificate repeatedly.

Another matter of concern in many DMHP is lack of transparency and poor maintenance of record of expenditure. There was no proper documentation of the implementation of DMHP for the entire period in a district. One peculiar aspect of handling grants from centre for DMHP in one state is that the fund used to be deposited in the state exchequer for a long time. The 1st installment of Rs. 26.2 lacs meant for East Siang DMHP (located about 250 Km from the state capital) was received in February, 2007. The grant was deposited in state exchequer . Surprisingly it is not handed over to the concerned district till date. This has prevented the humble beginning even after 3 years. Keeping the money of 1st installment for more than three years is violation of guidelines of the programme[9]. If unspent, the money should have been refunded with interest. Many programmes failed to spend the 1st installment even after several years.

As DMHP is a district level programme, the financial matters should be managed at district level. In most of the DMHP, the people working at the district level are totally unaware about the fund position and its utilization. There is a case where the fund is managed not by the nodal officer or DMHP team but by the member secretary of State Mental Health Authority working in a diffferent district. So, managing the programme from headquarter of a different district becomes an obstacle for successful implementation of the programme.

As per the scheme for strengthening the psychiatric wings of general hospitals and medical col1eges in the Government sector under revised NMHP, a one-time grant of Rs.50 lakhs for upgradation of infrastructure and equipment was received by many districts hospitals which are nodal centers for DMHP. The grant covers:

1. Construction of new ward.
2. Repair of existing ward.
3. Procurement of items like cots and tables.
4. Equipment for psychiatric use such as modified ECTs

The in-patient ward of a district hospital was renovated several times with these central grants. But even after expenditure of such a heavy amount the in-patient ward is found to be in poor shape. The small cubicle like set up is not suitable for hospitalization for psychiatric patients. The dilapidated floor and dirty wall is tell-tale evidence of utter neglect and mismanagement. There was only a single patient in the ward on the day of inspection. The arrangement in the ECT room speaks volume about its utilisation. The ECT machine is safely kept in locker. Layer of dust accumulated over the Boyles' apparatus. It seems it was never used since its purchase. In another district hospital, the grant received for development of psychiatric ward was spent for construction of office building. Equipments like modified ECT machine, Boyle's apparatus were purchased with the grant but never used as there is no indoor facility. The erstwhile 'Isolation ward' was earmarked as in-patient ward for psychiatric patient. Since no patient was treated as in-patient, the existing psychiatry ward is being used as 'Burn Unit'. On the other hand, some DMHPs which is doing a very good job is facing problem due to lack of provision of in-patient ward in the district hospital. They have to share beds with medicine department which creates conflicts at times.

In most of the districts under DMHP, the supply of psychotropic medicines is few and irregular. One DMHP psychiatrist commented that supply of surgical items even

without indent is more regular (though often unused) than psychotropic medicines. The reason behind this is well understood. There was occasion when medicine supplied was much more than required and hence major part of the consignment expired. The medicines are dispensed only in the district hospital. No essential psychiatric medicines are made available or dispensed at primary level.

There is another interesting case. As per record of Ministry of Health and Family Welfare, Government of India, there is a programme under DMHP in Darrang District of Assam and Gauhati Medical College is the nodal institute. But no such programme is going on in Darrang District of Assam. Neither Principal of Gauhati Medical College nor the State Nodal Officer received any grant so far for this district. This matter was already intimated to the Government of India by the State Nodal Officer. But we were asked to inspect that district recently by the Government of India. Government of India should probe about allocation of fund to Darrang DMHP. If no such sanction was made, the money should be released immediately so that the nodal institute can start the programme immediately.

At present the major issue of DMHPs which completed five year term is the regularisation of services of the staff working for DMHP by the state government. They were given consolidated pay only without any increment or allowances. For several years they worked without any pay for which many member of DMHP team already left the service. They were given infrequent financial assistance in the form of lump sum amount by the state government. But the staffs want their service to be regularised by the state government with pay packages at par with other state government employee which is very much justified. In order to make the programme successful, their grievances must be addressed by the concerned government. As stated in the NMHP guideline, it is mandatory on the part of the state government to take over the programme on completion of central assistance for a period of five years. But the genuine grievances of DMHP team working in the field are not reaching the officials sitting in state capital.

In all practicality, DMHP has become solely dependent on the DMHP psychiatrist in most of the districts. The medical officers who were trained under DMHP are no longer recording and reporting the number of psychiatric cases seen by them once it is taken over by the state governments. This is probably because of lack of communication. Even many nodal officers are not receiving any guideline from the centre. So, it is not surprising to know that there is no record of how many medical officers who were trained under DMHP are transferred to other districts or retired. No new training programme is undertaken after it was taken over by state government for lack of fund. In the monthly meeting also, record from the psychiatry department is hardly discussed.

The 11th Plan has a vision of district mental health programmes that include community mental health services like life-skill training and counselling in educational institutions, workplace stress management and suicide prevention services. Most of the DMHPs of this region did precious little in this regard. DMHP in current form is mostly focused on pharmacological management of psychosis only.

There is a goal of providing short-term training to deliver basic mental health services to the existing health staff in the districts by the end of the 11th Plan. This goal is unlikely to be achieved in the Plan period.

The role of State Mental Health Authority in implementation of the programme needs to be defined. In many states the state mental health authority is defunct or it is not very much sure about their roles and responsibilities. It should function as technical support team to assist the state nodal officer.

REMEDIAL MEASURES

As a remedial measure for such anomalies and for success of DMHP, frequent and timely monitoring is essential. In many cases the official who was responsible for implementation of the programme is no longer available due to superannuation, death or transfer. Many queries could not be clarified by the officials currently engaged with the programme. There is no point of monitoring a programme several years after it was completed. The idea

of monitoring is to find out the deficits so that timely corrective measures can be taken in order to make the programme successful. Continuous monitoring and reporting as well as regular external evaluation is recommended for mid-course correction. Utilisation certificate should not be taken at their face value. The staff working in DMHP should be regularized by the State government and instead of consolidated pay they should be given pay and allowances at par with other employees of state government. The medical officers who are yet to be trained under DMHP should be trained. There should be thorough verification of expenditure in various heads since inception of the programme. The programmes where posts of supporting staff are lying vacant should be recruited immediately and sent for training for stipulated period in the identified nodal institutes for the region. The in-patient ward should be made functional immediately. There should be an effective and time specific monitoring system. Periodic training of the health workers at primary level on priority mental disorders and their day to day supervision, along with monthly review of the mental health programme during the regular review of other health programmes will definitely play a significant role in proper implementation of DMHP. By this process, the mental health programme will not be seen as separate from the other health programmes. Mental health services at subcenter, PHC, CHC level should be strengthened so that the services become more accessible to the patients[7]. Most of the DMHP failed to provide disability certification on a monthly basis. The involvement of Panchayat Raj institutions and voluntary organizations for community level rehabilitation of patients, including the setting up of support to self-help groups is almost nonexistent.

Central Government in consultation with State Governments should ensure continuity of DMHP beyond the plan period by an undertaking to this effect and integration of mental health services in State and District Programme Implementation Plan (PIP). The fund allotment should be regular and timely. Initiation of programme should be ensured in time bound manner after the receipt of funds[7]. The salary of staff should be revised. The salary of DMHP psychiatrist and the faculties under NMHP is so less that it is unlikely that these posts will be filled up even if there is sufficient manpower until and unless there is revision of the remuneration. The DMHP psychiatrists are mostly from state health cadre and therefore they are not spared from other emergency duties. They do not get any incentive also for working in DMHP. So, there is resentment and some of them consider it to be an extra burden. The staff of the DMHP should be exclusively engaged for programme related works. Training should be imparted regularly to all members of the DMHP team. Refresher training and in-service training with the focus on local challenges will boost up the morale of the personnel implementing the programme. Training the DMHP team in organizational skills, networking and involvement of all stakeholders is also important. The trained personnel should be retained in the district or if transferred it should be to other DMHP districts only. The DMHP team needs to be trained on Programme Management and organizational activities[7]. It is recommended that in addition to diagnosis and treatment involvement of family members and community in the treatment process should be stressed. Counseling should be an integral component in each step. Proper mechanism should be evolved for drop out cases by ensuring availability of psychiatric social worker and community nurse to follow up the drop out cases. The involvement of PRIs and local leaders can make this much easier. The programme should emphasize on promotive and preventive aspects rather than curative only. So, suicide prevention, workplace stress management, school and college counseling services etc should be incorporated at each level. Though there is enough discussion about integration/ coordination of mental health programme with other health programme like. ICDS, NRHM this is far from reality. There is urgent need for regular inflow of medicines and availability at primary level. Drug procurement mechanism should be streamlined to reduce delay in procurement and achieve economy of scale (e.g. Tamil Nadu model)[7].

There should be regular review of the case Records by the DMHP officer/ team for completeness of the records; correctness of the diagnosis, appropriateness of the medicine used, appropriateness of the dosage of the medicine, follow-up records-completeness, appropriateness of changes in the treatment, Medicine stock etc. The record and work of health workers should

be evaluated and their problem should be discussed. Most of the DMHP failed to initiate any programme for support of the caregivers. Community resources like families were not accorded due importance. Most important is that the nodal officer should be a psychiatrist. Non Psychiatrist nodal officers overburdened with other responsibilities and having no technical expertise failed to give justice to their responsibilities particularly when the central guidance is inadequate.

It was indeed a good idea to expand this programme to each districts of the country during 11th five year plan period. But it has not been possible due to flaws that are discussed already. The core idea of integration with the general health service is not implemented at the operational level. With proper monitoring and active involvement of all sections of people definitely DMHP can lessen the sufferings of millions of mentally ill and their families and promote mental health in the society.

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